Filed 4/5/19 In re A.Y. CA6

NOT TO BE PUBLISHED IN OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SIXTH APPELLATE DISTRICT

In re A.Y. et al., Persons Coming Under the Juvenile Court Law.	H045197, H045299 (Santa Clara County Super. Ct. No. JD024443)
SANTA CLARA COUNTY DEPARTMENT OF FAMILY AND CHILDREN'S SERVICES, Plaintiff and Respondent, v. S.Y. et al., Defendants and Appellants.	

On April 13, 2017, the Santa Clara County Department of Family and Children's Services (Department) filed a petition under Welfare and Institutions Code section 300, subdivisions (a), (b)(1), and (e)[1] relative to an infant boy, A.Y. (the minor). The minor was three and one-half months old at the time, having been born in December 2016. A.M. (mother) and S.Y. (father) are the minor's parents. (Mother and father are hereafter collectively referred to as parents.) The Department alleged that the minor, after

[1] Further statutory references are to the Welfare and Institutions Code unless otherwise stated.

suffering prolonged seizures for which he was admitted to Kaiser Hospital in Santa Clara (Kaiser Santa Clara) on April 11, 2017, was diagnosed as having injuries consistent with abusive head trauma. The day after the diagnosis, Sunnyvale police placed the minor in protective custody.

In August 2017, after a 10-day contested jurisdiction hearing, the juvenile court found by a preponderance of the evidence that the allegations of the petition, as amended, were true, concluding that the minor was a child described by subdivisions (a), (b), and (e) of section 300.[2] The evidence central to the Department's petition concerned the diagnosis of Dr. Catherine Albin, the treating pediatrician and an expert in physical child abuse, who provided extensive testimony at the hearing. Dr. Albin consulted with a multidisciplinary team of colleagues at Kaiser Santa Clara, including Dr. Ramin Saket, a pediatric neuroradiologist, who prepared a report interpreting cranial magnetic resonance imaging (MRI) upon which Dr. Albin relied. Dr. Albin testified the minor had sustained multiple subdural hematomas of multiple ages, including a recent one, had scattered subarachnoid hemorrhages, and a shearing injury to the brain itself. Based upon this diagnosis and the absence of any explanation by parents for the injuries, Dr. Albin concluded the minor had sustained abusive head trauma that was nonaccidental.

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[2] "A child who comes within any of the following descriptions is within the jurisdiction of the juvenile court which may adjudge that person to be a dependent child of the court: [¶] (a) The child has suffered, or there is a substantial risk that the child will suffer, serious physical harm inflicted nonaccidentally upon the child by the child's parent . . . . [¶] (b)(1) The child has suffered, or there is a substantial risk that the child will suffer, serious physical harm or illness, as a result of the failure or inability of his or her parent . . . to adequately supervise or protect the child, or the willful or negligent failure of the child's parent . . . to adequately supervise or protect the child from the conduct of the custodian with whom the child has been left . . . . [¶] . . . [¶] (e) The child is under the age of five years and has suffered severe physical abuse by a parent, or by any person known by the parent, if the parent knew or reasonably should have known that the person was physically abusing the child." (§ 300.)

Mother called two medical expert witnesses, an emergency room physician/clinical forensic medical specialist, Dr. Stephen Gabaeff, and a radiologist, Dr. Susan Gootnick. The two experts opined that the minor had not suffered abusive head trauma; rather, his condition, as shown on the MRI and from other testing, was attributable to a difficult birth and recently contracted meningitis.

The Department, over mother's objection, presented testimony from Dr. Saket, the pediatric neuroradiologist who examined and reported on the minor's MRI scans, in rebuttal to the testimony of mother's radiologist expert. Because—mother argued—Dr. Saket presented new evidence, mother requested leave to present surrebuttal expert testimony by Dr. Patrick Barnes, a physician affiliated with Stanford Hospital and represented by mother's counsel to be a world-renowned pediatric neuroradiologist. Father joined in the request. The juvenile court denied mother's request, finding that Dr. Saket had not presented new evidence in rebuttal that warranted mother's presentation of surrebuttal evidence from Dr. Barnes. The court also denied mother's subsequent motion to strike Dr. Saket's testimony.

After finding the allegations of the amended petition true at the jurisdiction hearing, the juvenile court conducted the disposition hearing. At that hearing, the court adjudged the minor a dependent child and removed him from parents' care and custody. Parents reunified with the minor in February 2018. In June 2018, when the minor was approximately 18 months old, the court dismissed the dependency proceedings.

Parents filed separate appeals from the order after the jurisdiction/disposition hearing, challenging the jurisdictional findings. They contend that the trial court abused its discretion and violated their constitutional due process rights by refusing to permit mother to present the surrrebuttal expert testimony of Dr. Barnes. Parents argue in the alternative that the trial court abused its discretion and violated their constitutional due process rights by refusing to strike the testimony of Dr. Saket on the basis that it was not

proper rebuttal testimony and therefore should have been presented in the Department's case-in-chief.

Based upon a careful review of the record, it is clear to this court that the Kaiser Santa Clara staff, after performing a thorough examination of the minor, acted reasonably to protect the minor in response to life-threatening injuries. It is also clear that parents demonstrated from the time of the minor's birth until he was detained that they were very diligent, affectionate, and loving in their care of the child. And the record demonstrates that the juvenile court acted with patience, thoroughness, and thoughtfulness in presiding over the lengthy jurisdiction hearing and the disposition hearing. In considering this appeal, we acknowledge the broad discretion with which trial courts are vested in deciding the admissibility of evidence in general (*People v. Williams* (1997) 16 Cal.4th 153, 197), and in determining the propriety of admitting rebuttal and surrebuttal evidence in particular (*People v. Kelly* (1990) 51 Cal.3d 931, 965 (*Kelly*) [rebuttal]; *People v. Lamb* (2006) 136 Cal.App.4th 575, 582 (*Lamb*) [surrebuttal]). And it is the unusual case in which an evidentiary ruling claimed to be erroneous will rise to the level of federal constitutional error. (*People v. Albarran* (2007) 149 Cal.App.4th 214, 232.) We conclude that this is a case that is indeed unusual.

Of paramount consideration here is that the excluded surrebuttal evidence directly concerned *the* critical issue in the case, i.e., whether the medical evidence demonstrated that the minor had sustained abusive head trauma that was nonaccidental, or, alternatively, whether there were innocent explanations (i.e., birth injury and infection) for minor's medical condition. Other important circumstances are, inter alia, that (1) the subject of the evidentiary exclusion order concerned complex medical issues that were heavily contested and subject to extensive expert testimony; (2) although the court initially permitted Dr. Saket to testify as a rebuttal expert for the limited purpose of responding to the foundation of the opinions provided by mother's radiological expert, Dr. Saket ultimately provided testimony beyond the scope of rebuttal evidence;

(3) Dr. Saket testified to medical issues that had not been specifically addressed by parents in their case-in-chief and about which they had no notice before the hearing, including that his report had not taken into account the minor's meningitis, of which Dr. Saket had been unaware at the time he had prepared the report; (4) Dr. Saket rendered new opinions and testified to new matters, including opining that meningitis had not caused subdural hematomas or other abnormalities shown in the MRI scans; and (5) mother's offer of proof was that Dr. Barnes would respond to new issues raised in Dr. Saket's testimony.

Based upon the facts and unique circumstances presented here, we conclude that the juvenile court should have permitted mother to present the surrebuttal testimony of Dr. Barnes. In a case such as the one before us, and given the potential significance of the excluded surrebuttal evidence in light of Dr. Saket's testimony, we cannot say the error was nonprejudicial. In so concluding, we express no opinion concerning the merits of the issues to be resolved by the juvenile court in the jurisdiction hearing.

We will, accordingly, reverse the order after the disposition hearing of August 23, 2017, and the underlying jurisdiction order of August 3, 2017.

I. FACTS AND PROCEDURAL HISTORY

A. Petition and Detention Order (April 2017)

On April 13, 2017, the Department filed a petition on behalf of the minor (born December 27, 2016) under subdivisions (a), (b)(1), and (e) of section 300. The Department alleged, inter alia, that (1) there was a substantial risk that the minor had suffered or would suffer serious physical harm or illness, (2) the risk of substantial harm was due to the parents' failure or inability to supervise or protect him, (3) said parental neglect was negligent or willful, and (4) the minor was under the age of five and had suffered severe physical abuse by the parent and the parent knew or reasonably should have known that the parent was physically abusing him.

The Department alleged in the petition that on April 11, 2017,[3] the minor—then three and one-half months old—was brought by parents to the emergency room of Kaiser Santa Clara because he had a fever, was moaning, and was vomiting. He was diagnosed with having seizures, and it was determined from a cranial MRI that there was "significant bleeding in the child's brain, and that there were two separate injuries of different ages." One injury had occurred two to six weeks earlier, and the second injury was more recent. The results of a spinal tap were abnormal in that blood was found, which is consistent with the patient having suffered an impact injury. And "[t]here was mechanical shearing of the brain tissue. The medical professionals determined that the child's injuries [were] non-accidental" and were "consistent with Shaken Baby Syndrome."

Parents were interviewed by child welfare workers and representatives of law enforcement. Parents stated the minor had been cared for by only parents and the maternal grandparents in parents' Sunnyvale apartment, and parents denied that they or the grandparents had caused the minor's injuries. The Department concluded parents had not reasonably explained the cause of the minor's injuries, and that "[t]he injuries sustained . . . [were] of a nature as would ordinarily not be sustained except as the result of the unreasonable or neglectful acts or omissions of either parent or other person who ha[d] cared for the child."

On April 12, the Sunnyvale Police Department placed the minor into protective custody.[4]

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[3] All dates are 2017 unless otherwise stated.

[4] The Department filed an amended petition on June 12. The amended petition is substantially the same as the original petition but provided additional language specifically identifying the treating physician as "Dr. Catherine Albin, [a] child abuse expert," who conducted a thorough assessment and determined that the minor's injuries "were most likely caused by trauma inflicted non-accidentally and neither parent ha[d] a reasonable explanation for the injuries."

On April 14, the juvenile court found that a prima facie showing had been made that the minor came within section 300, continued residence in the parents' home was contrary to the minor's welfare, and that continued detention was necessary because there was substantial danger to the physical health of the minor. The court ordered the minor detained in the care, custody, and control of the Department. Mother and father were granted the right to supervised visits of the minor for a minimum of two hours, two times per week.

B. Jurisdiction/Disposition Report (July 2017)

The Department reported that the minor, after having been admitted to Kaiser Santa Clara on April 11, was discharged on May 2. The minor had been initially placed in a County-certified Emergency Satellite Home. On May 25, the minor was placed with the paternal uncle in parents' former Sunnyvale apartment; parents moved out of the home to facilitate that placement.

The Department's jurisdiction/disposition report detailed the minor's medical history, the circumstances of the minor's hospitalization on April 11, medical reports pertaining to that hospitalization, and the substance of interviews conducted with members of the minor's family.

1. Minor's Medical History

The minor was born premature (36 weeks gestation) in December 2016, weighing five pounds, 15.2 ounces. At birth, he had neonatal jaundice and neonatal hypoglycemia. The minor received his first round of immunizations in March.

Prior to the minor's hospitalization on April 11, he had been brought by parents to the Kaiser Santa Clara emergency room on April 7 because of a high fever. On the night of April 6, parents reported the minor "had an 'unprovoked vomit.' " The minor was moaning repeatedly, he had a fever, and mother was unsuccessful in attempting to bottle-feed him. The medical provider at Kaiser Santa Clara noted that the fever—which was 100.1 degrees upon arrival at the hospital—was not associated with any kind of illness

and that the minor had a high heart rate. The staff performed a urinalysis; the results were abnormal because there was blood in the urine, which could have occurred because of the catheter used to obtain the urine. It was believed by Kaiser Santa Clara staff that the minor had an infection that had yet to be determined. The minor appeared to be fine and was discharged on the morning of April 7 after receiving antibiotics.

2. April 11 Hospitalization & Medical Reports

According to statements made by mother, on the morning of April 11, the minor's right arm started shaking, his right eye was blinking, and he was staring toward the right side. The seizures reportedly lasted for 40 to 45 minutes before mother took the minor to Kaiser Santa Clara. The minor received several anti-seizure medications that initially were ineffective. The treating physician, Dr. Catherine Albin, advised that it required an atypical quantity of medication to control the seizures.

A cranial MRI showed: "[1] Large left frontoparietal convexity acute superimposed upon chronic subdural hematoma and multiple membranes/adhesions and small amounts of superimposed acute/subacute blood products[; 2 s]mall right frontoparietal convexity subacute superimposed upon chronic subdural hematoma versus age-indeterminate hematohygroma[; 3 s]cattered acute subarachnoid hemorrhage[; and 4 m]ultiple foci of micro-hemorrhagic shear injury involving the right caudal thalamic groove, bilateral occipital lobes, and bilateral cerebellar hemispheres." It was stated in the report that "[c]onstellation of findings would be highly congruent with nonaccidental trauma."

The hospital performed a spinal tap of the minor. Dr. Albin reported that the results were abnormal because of the presence of blood, a circumstance she opined was typical of an impact injury.

After referral of the matter to the Department, an emergency response social worker spoke with Dr. Albin at the hospital. Dr. Albin advised that the MRI disclosed that there had been "significant bleeding in the child's brain, and that there [were] two

separate injuries of different ages, which was consistent with Shaken Baby Syndrome. . . . [T]here were two different brain bleeds noted: the first being approximately two to six weeks old, and a newer bleed. . . . [Also,] there was mechanical shearing of the brain tissue itself." Dr. Albin opined "that lab results so far seem[ed] to indicate that the abuse 'has been going on for a long time,' and other indicators point[ed] to possible injuries that [were] historical and the child [was at time of admission] experiencing neurological complications that [were] potentially life-threatening."

Dr. Albin noted there was a "[n]egative retinal exam, no evidence of other injuries—old or new. However[,] this does not preclude the presence of healed/resolved hemorrhages that may have been coincident with one of the earlier subdural hemorrhages/injuries[.]" Dr. Albin also diagnosed the minor as having E. coli meningitis. She opined that "[t]he presence of [this] second serious diagnosis . . . is NOT an associated finding with subdural hematomas. . . . [G]iven the multiple ages of the hematomas, it is impossible that this acute E. coli infection is the cause. . . . [I]t is more likely that during the traumatic event (ie shaking), bacteria invaded the normally sterile CSF [(cerebrospinal fluid)] thru blood leakage into this same space (blood in CSF-LP data- and blood in the subarachnoid spaces seen on MRI)." (Original capitalization.)

In Dr. Albin's report, she offered the following differential diagnosis: "The MRI findings of subdural hemorrhages of multiple ages, acute neurologic symptoms (i.e., seizures), bloody CSF and evidence of shear injury to the deeper structures of the brain, meet criteria for abusive head injury. (Shaken Baby Syndrome) Although retinal hemorrhages (either unilateral or bilateral) are highly associated with shaken baby syndrome, [i]t is not a critical component of the syndrome[.] [¶] A[] single injury (even unwitnessed) is not consistent with the MULTIPLE ages of bleeds." (Original capitalization.)

Dr. Albin advised the Department that she believed the minor would heal and continue to improve. Dr. Albin opined that the minor's "development will be minimally

affected at this point and he can still lead a normal life." She opined that the head trauma would take approximately one year to heal completely; during that period, a small injury could result in further damage and injuries similar to those the minor had previously experienced could prove fatal. "Dr. Albin noted that [the minor] is at risk for multiple long term problems, which include but are not limited to deafness, generalized[] speech and motor developmental delays, long term seizure disorder . . . and learning disabilities."

3. Interviews

Dr. Albin advised parents on April 11 that the minor had sustained head injuries that were nonaccidental, and she demonstrated to them the nature of the shaking that could have resulted in the injury. Parents denied any trauma, and they stated that there were only four adults—mother, father, maternal grandmother, and maternal grandfather—who lived in the home and had cared for the minor. Dr. Albin reported that "[m]other was adamant that her parents would never harm the baby. She never made the same effort to deny that she or father would not [*sic*] harm the baby." Before Dr. Albin informed parents of her suspicions that the minor had been shaken, they had told her that the minor had not been injured as a result of an accident and had said that the maternal grandparents would never hurt the minor. Dr. Albin also observed that "[s]hortly after [parents] were informed that CPS was notified, mother went home, leaving father at the bedside. She did not return until late the next day. This is an unusual behavior for a parent who has been just informed of a very serious and potentially life[-]threatening diagnosis."

In an interview conducted by law enforcement, father denied that the minor had been dropped, had fallen, had been involved in any car accidents, or had been shaken by anyone in the home.

Father was interviewed on April 12 by social worker Brian Hawkinson. Father denied having shaken the baby and denied that the minor had fallen off the bed or that the minor had been dropped. Father noted that after the minor received immunizations when

he was two months old, the baby began acting differently. Father also posited innocent explanations for the minor's injuries, such as having received them while on a baby swing or when he was placed in the bassinet or car. Father could not explain how the minor's injuries had occurred.

Social worker Hawkinson spoke with mother by telephone on April 12. Mother "stated that she and the father were extra cautious with the child because he was born premature." She denied the minor had been harmed under the care of her parents, father, or herself. Mother stated the minor may have been harmed while he was in the baby swing; she could not think of any other circumstance. Mother then asked why the social "worker or the hospital was not looking into other possibilities . . . and cited that the child was born with low blood sugar, was premature and had jaundice and those [conditions] also did not have an explanation provided for how those happened. . . . [The mother] stated[,] 'I don't think anything happened to cause trauma.' "

The maternal grandparents were interviewed by Sunnyvale police officers and Hawkinson on April 24. The maternal grandmother, J.M., stated that she had arrived from India in late December 2016 to assist in caring for the minor. She stated that the minor had "been easy to care for, 'not so bad,' and that he 'sleeps through the night.' " J.M. had routinely cared for the child between 2:00 and 3:00 a.m. so that father could sleep. She denied that the minor had been hurt or that anyone in the household had shaken him; J.M. denied knowing how the minor had been hurt. She said that mother was " 'very patient and [a] nice person,' and that the mother ha[d] not been acting differently." J.M. explained that mother and father had told her the minor had been hospitalized for a bacterial infection and they did not tell her that the minor had been placed into protective custody.

The maternal grandfather, S.M., told the police on April 24 that the minor had been hospitalized because he had " 'a small injury, a blood clot.' " S.M. stated that he did not know how the injury had occurred. He said he occasionally cared for the minor,

that mother was the minor's primary caregiver, then J.M. "when 'her time freed up' then the father in the evening when he was off . . . work." J.M. also cared for the minor between 2:00 and 3:00 a.m. S.M. stated that he, as well as everyone in the family, knew that the minor was in protective custody. S.M. denied the minor had received any injuries.

4. Department's Recommendations

The Department concluded that it had no doubt that parents loved the minor as they visited him frequently and expressed their view that they would do whatever was necessary to have the minor returned to their care. The Department, however, expressed significant concerns about the welfare of the minor based upon (1) the severity of the head injuries to the minor (multiple subdural hematomas and brain shearing and blood in the spinal fluid) that occurred on multiple occasions, (2) the medical conclusion that the injuries were the result of nonaccidental injuries consistent with Shaken Baby Syndrome, (3) parents' inability to offer any explanation for the injuries, and (4) the fact that the minor has been in the sole care of his family. Because of the absence of a plausible explanation for the minor's injuries from mother, father or the maternal grandparents, the Department concluded that the minor was at a high risk of further physical harm were he returned to the home. The Department therefore recommended that the minor remain in out-of-home placement and that parents receive family reunification services and take classes in child abuse and parenting without violence.

C. Jurisdiction Hearing (July-August 2017)

A 10-day contested jurisdiction hearing took place between July 11 and August 3.

1. Department's Evidence

The Department submitted its jurisdiction and disposition report (May 8) and first addendum (June 26). It called the following witnesses: mother, social worker Hawkinson, and Dr. Albin.

a. Testimony of Mother

Mother testified that the minor was born approximately four weeks early. She had a difficult delivery that took approximately four and one-half hours, and she believed the minor might have experienced resulting trauma.

In January and February, mother suffered from a skin condition that resulted in rashes for which she used a steroidal cream. This condition limited the amount of time she could hold the minor. Mother testified that physicians suspected it was eczema but did not give the condition a conclusive diagnosis. In January, at a routine postpartum appointment, mother provided information about her well-being to the doctor, including completion of a questionnaire in which she reported feeling down or depressed or hopeless more than half the days in a two-week period.

Early in the morning on April 7, mother brought the minor to the emergency room because he was suffering from a fever and was moaning. At the hospital, the minor had a 102-degree fever. He was catheterized so that the hospital could obtain a urine sample to determine if he had an infection. The minor was given Tylenol and his fever decreased. He was discharged by the hospital at approximately 8:30 a.m. that morning.

After his discharge, the minor improved but continued to have a fever. Parents gave him Tylenol and he slept more than usual. On the evening of April 8, parents were informed by the hospital that the minor had "some urine infection," and he was prescribed antibiotics. By April 10, the minor seemed better and was interacting more than before. That evening, he had a fever of 103; he was given Tylenol, which reduced the fever. Because the minor was not feeling well, mother stayed up later than normal with him that night—until approximately 4:00 a.m. on April 11.

After 10:00 a.m. the next morning (April 11), mother observed that the minor's right hand was shaking and his right eye was blinking rapidly. He was shaking constantly. Mother—who does not drive—asked her brother-in-law to drive her and the minor to the hospital.

Mother stayed at the hospital until approximately 8:30 p.m. on April 11. She left before the police arrived. She explained that her mother (J.M.) "was dizzy and she fell," and so mother took her home. Mother returned to the hospital on April 12 at approximately 5:00 p.m. She testified that she had not gone to the hospital earlier on April 12 because she had initially planned for her husband to take her, but he had stayed at the hospital; later, she had waited at the apartment because she had thought a social worker would be coming by to speak with her.

Mother denied ever having shaken the minor. She denied that she or her family members harmed the minor. She testified that she asked father, J.M., and S.M. whether they had shaken the minor; each of them said they had not. Mother testified that, in addition to the minor's difficult delivery, the minor's neonatal vaccinations and his unusual head size may have contributed to his injuries.

b. Testimony of Brian Hawkinson

Brian Hawkinson was the primary supervising social worker in this case. The court qualified him as an expert in the area of risk assessment for minor children.

He testified that on April 12, Dr. Albin advised him of her diagnosis that the minor had two head injuries—subdural hematomas—of different ages and an injury consisting of a mechanical shearing of the brain. She told him that "a significant event" would have been required to have caused the minor's injuries.

Hawkinson opined that there were additional risk factors in this case that included the following circumstances: (1) the minor was unable to communicate whether or not he had been abused; (2) the minor was under six months old, thus tending to cry more often as his only way of communicating; (3) the minor was parents' first child, there being an increased risk to children under the age of one because first-time parents have not previously experienced issues of fussiness and crying; (4) parents reported the minor as having been fussy and colicky, increasing the risk of parents becoming more frustrated and irritable; (5) parents reported the minor was a poor sleeper, with a pattern of having

no long periods of sleep and being awakened every one and one-half to two hours at night for feeding[5]; (6) mother reportedly had not gotten long periods of uninterrupted sleep; (7) mother reportedly had eczema that limited the amount of time she could hold the minor, thus impacting her bonding with him; and (8) there were concerns about mother's mental health, based upon her self-reporting on January 27 and in early March that she "was not finding pleasure" and felt "down and depressed," and Hawkinson's observation of mother's generally having "a very flat affect" in communicating with him.

Based upon the above-stated increased risk factors, the medical evidence explained to him by Dr. Albin, and there having been no plausible explanation given by parents for the minor's injuries, Hawkinson concluded that intervention on behalf of the minor was required.

c. Testimony of Dr. Catherine Albin

i. Qualifications

Dr. Albin is a licensed physician with approximately 30 years of experience. At the time of the hearing, she was the director of the Northern California pediatric intensive care unit (ICU) for Kaiser Permanente Group and a pediatric intensive care physician responsible for patient care at the Kaiser Santa Clara pediatric ICU. Dr. Albin is trained as a general pediatrician with special training in pediatric critical care medicine; she also holds a Ph.D. in infectious diseases. She also has expertise in the area of physical child abuse. She testified both as the minor's treating and admitting physician and as an expert witness in the field of the identification and diagnosis of child abuse.

Dr. Albin testified that she had been involved in the clinical aspects of identifying potential instances of child abuse. She had been involved in approximately 50 cases of

[5] On cross-examination, Hawkinson clarified that parents had advised that the minor was awakened for feeding every three hours, and it had been only recently that his sleep had reduced to one and one-half to two-hour intervals.

suspected child abuse in the year prior to the hearing; approximately 40 percent of those cases were found by her to warrant further investigation, and 10 percent of those cases were ones in which she concluded that actual child abuse was involved.

ii. Treatment and Testing

Dr. Albin testified that the minor came into the Kaiser Santa Clara emergency room on the morning of April 11. He presented with "protracted and prolonged seizures." The emergency room staff performed routine tests, including a blood culture test, and treated the minor with several doses of antiseizure medication. After the seizures appeared to have been addressed, the minor was transferred to pediatric ICU, where Dr. Albin first saw the minor and mother.

Dr. Albin conducted a thorough examination of the minor, during which she noted that his seizures had resumed. She saw no indications of physical abuse. The minor did not present with symptoms of acute meningitis. After her initial examination, Dr. Albin ordered a cranial MRI and a spinal tap. MRI evaluation is a standard response to assessing a child patient who is having seizures for the first time. And a spinal tap to test the cerebral spinal fluid (CSF) is appropriate because seizures are commonly caused by meningitis or other metabolic diseases. Dr. Albin contacted a pediatric neurologist to perform the spinal tap.

The spinal tap yielded a bloody sample; because the CSF is a sterile area where no blood is typically present, the results of the minor's spinal tap were unusual. Given that the minor did not have a fever, did not present as being extremely sick (other than the presence of seizures), and bacteria had not grown from his blood culture, Dr. Albin was surprised when she later received the laboratory results of the CSF sample showing the presence of E. coli. Dr. Albin performed a second spinal tap the next day; the CSF sample was not bloody, but was brown and blood-tinged. She testified: "E. coli meningitis in the newborn period is a particularly malignant kind of meningitis. Children are very ill. They tend to get sick very quickly."

iii. Diagnosis and Opinions

Dr. Albin described the minor's case as one that required extensive discussion with many of her colleagues, and diagnosis and treatment required "multidisciplinary" involvement that included one or more radiologists, pediatric neurologists, neurosurgeons, critical care physicians, and specialists in infectious diseases. Her report incorporated the findings from the cranial MRI in the report prepared by pediatric neuroradiologist, Dr. Ramin Saket. Dr. Albin testified that it was an "unusual" case in that there were "two simultaneous diagnoses [subdural hematomas and E. coli meningitis] that complicate each other."

As a preface to her opinion testimony, Dr. Albin generally identified and described the human brain and surrounding areas. She explained that the brain is itself very soft and can be easily injured, with an infant's brain being more susceptible to injury. Working outward from the brain to the skull, the areas are identified as the subarachnoid space, the arachnoid membrane, the subdural space, and the dura. The subarachnoid space normally contains no blood and is where the clear CSF exists that is obtained in spinal taps.

Dr. Albin testified that, based upon her examination of the patient, his medical history, the cranial MRI scans, and the spinal taps, the minor presented with multiple subdural hematomas of three different ages: ones that were acute (occurring up to 72 hours prior), subacute (occurring between one and three to four weeks prior), and chronic (occurring more than three to four weeks prior). The hemorrhaging was scattered in different locations. Dr. Albin opined that the original injury could have been as much as six to eight weeks prior to April 11. In her opinion, the multiple "scattered subarachnoid hemorrhages around the surface of the brain and in many different locations" were "[m]ore likely associated with some trauma." Generally, Dr. Albin opined, the presence of multiple subdural hematomas reduced the probability of them

having been from a benign cause; they are "highly specific for multiple episodes of head injury usually associated with abuse."

Dr. Albin opined that the minor had suffered an acute injury because the minor presented with "severe neurologic symptom[s]," "protracted and prolonged seizures," had a bloody spinal tap, and his MRI scans showed evidence of neurologic injury. She testified further that during her examination, she observed that the minor had "this very unusual repetitive tongue thrust that was virtually continuous." This behavior had been reported by parents approximately one month before his hospitalization on April 11 for seizures. Dr. Albin concluded the tongue thrust was an abnormal neurologic symptom, and she opined that it was caused by prior head trauma as evidenced by earlier brain bleeds. Based upon her entire review, Dr. Albin opined that "at least three different traumatic events occurred." She concluded that, given that the minor presented with seizures and "acute bleeding," the last traumatic event had occurred within 24 hours of the minor's April 11 admission at Kaiser Santa Clara.

Dr. Albin testified the MRI results also disclosed that the minor had shearing in the brain itself, which is commonly associated with an acceleration-deceleration injury in which the brain tissue stretches in opposite directions and tears. Generally, a brain shear injury is one in which the brain parenchyma (tissue) "is distorted in a way where the architecture of the nerve cells and the blood vessels to them [is] disrupted." Dr. Albin testified that the shear injury here was not caused by the minor's seizures. The presence of shearing resulted in Dr. Saket's having advised Dr. Albin of his concern that there had been a traumatic injury to the minor.

The meningitis that was disclosed from the results of the first spinal tap was, in Dr. Albin's opinion, of very recent origin.[6] Her conclusion was based upon (1) the

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[6] The Department in respondent's brief includes definitions of several medical terms, including meningitis, with citation to a National Institute of Health Website. These references were not part of the record below, and we will not consider them. (*In re*

absence of a high white blood cell count in the second CSF sample taken on April 12; (2) the fact that testing of the blood culture taken on April 11 did not result in the growth of E. coli and did not show an elevated white blood cell count indicative of infection; (3) the minor's having not been febrile on April 11; (4) the minor's having not presented on April 11 with bulging fontanelle (the " 'soft spot[]' " of a baby's skull), which is a meningitis symptom; and (5) the fact that, because of the aggressive nature of E. coli meningitis, the patient would have presented as very sick on April 11 if the meningitis had been at least several days old and had not been treated. Dr. Albin opined that the minor's meningitis occurred as a result of a brain trauma that the minor experienced on the day of his admission (April 11) or the night before his admission, in which blood containing bacteria leaked into the minor's CSF after a traumatic event. She opined further that the meningitis was not the cause of any of the minor's subdural bleeding, but it did complicate his recovery.

Dr. Albin testified that she did not know the specific mechanism that had caused the minor's injuries. She had not found evidence of impact. The multiple subdural hematomas of different ages, brain shearing, and acute blood in the CSF were consistent with multiple episodes of abusive head trauma caused by rapid acceleration and deceleration. Shaking is one example of a medium of rapid acceleration and deceleration that could cause hemorrhages. Her opinion that the minor suffered traumatic injury based upon rapid acceleration and deceleration was based upon the minor's having subdural hematomas of three different ages, the absence of any explanation from parents for the

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K.P. (2009) 175 Cal.App.4th 1, 5. [citation in appellate briefs to evidentiary matters purportedly found on Internet that were not considered by trial court is inappropriate would not be considered].)

injuries, the fact that such hematomas and brain shearing do not naturally happen, and there having been no alternative medical explanation for them.[7]

iv. Interviews and Impressions

Dr. Albin interviewed parents after the minor had received a cranial MRI. At the outset, she asked them a number of questions designed to elicit potential explanations for head trauma, such as falls, motor vehicle accidents, or having run into something with a stroller. Parents "were absolutely sure that there had been no trauma they could identify." Dr. Albin also asked parents whether the minor had ever been cared for by anyone besides family members. Parents responded they were certain no one else had cared for the minor and "they were absolutely sure that there had been no trauma they could identify."

Mother told Dr. Albin that she had had a rash that had been very painful to the extent she could not physically hold the minor to breastfeed him. Mother said she had also found it difficult to hold the minor in other positions. She told Dr. Albin that the rash had resolved in recent weeks and she had been able to care for her baby again but had not resumed breastfeeding.

There were several elements of parents' response to the minor's medical emergency that were of concern to Dr. Albin. First, after the minor had been having seizures for at least 10 to 15 minutes at home, mother, rather than calling 911 for an ambulance, had the paternal uncle drive her and the minor to the hospital. This was "not an appropriate intervention." Second, after Dr. Albin asked mother specifically about any episodes that could have resulted in harm to the minor or whether anyone could have hurt him, mother responded by repeatedly saying "that her parents would never hurt the

[7] The minor was tested by an ophthalmologist for retinal hemorrhaging, but none was found. Dr. Albin testified that studies showed that while retinal hemorrhaging was common in cases of rapid acceleration-deceleration (or shaken baby syndrome), such hemorrhaging was not found in approximately 25 percent of such cases.

baby; that they should not be considered to be a risk to the baby." During the exchange, mother never denied that she herself had hurt the baby. Dr. Albin testified that mother "was very, very, very clearly protecting her parents. It's . . . unusual." Third, after Dr. Albin discussed her diagnosis with parents and advised them of the seriousness of the medical issue, mother left the hospital and did not return until the next afternoon. Dr. Albin described mother's having left her "very ill child's side for that many hours" as "decidedly unusual." Fourth, prior to mother's leaving the hospital on April 11, Dr. Albin asked her if the maternal grandparents would want to visit the minor in the ICU; mother "felt that they should not see the baby."

2. Parents' Evidence

a. Testimony of Father

Father testified that the minor was born approximately four weeks premature and that mother had a very difficult delivery. At one point because of a lack of progress in the delivery, mother was given Pitocin to induce delivery. The baby was in neonatal ICU for six days, and he had hypoglycemia and jaundice.

Father testified that on the evening of April 6 after he arrived home from work, the family reported to him that the minor had slept more than usual; he seemed to father to be in good health but he spit up more milk than usual after feeding. Later that night, at approximately 1:00 a.m., mother awakened him and told him the minor was moaning. After taking his temperature and determining that it was 101 degrees, parents called the health nurse to ask for advice. The nurse recommended taking the baby to the hospital. At the hospital, staff obtained a urine sample for testing. After two catheterizations, the sample was obtained. The initial results were reported by the hospital to be negative. The hospital advised them at approximately 8:30 a.m. that they could take the minor home and continue giving him Tylenol for his fever. After the minor returned home, his temperature fluctuated on April 7 and 8. Parents gave the minor Pediolyte for dehydration.

On the evening of April 8, a doctor or a nurse from the hospital called father and advised that test results had shown that the minor had an E. coli bacteria count of between 10,000 and 50,000. The doctor or nurse explained that a count of less than 10,000 meant no infection, and a count of more than 50,000 meant there was an infection. She asked father to watch for a high temperature or for poor feeding. Father and mother noticed that evening that the minor's temperature was fluctuating and he pushed out the bottle with his tongue when they tried to feed him. The next morning, during a telephone appointment, a physician prescribed antibiotics (Keflex) to be given to the minor. Father testified that after having received two doses of Keflex, the minor on the evening of April 9 continued to have fluctuating temperatures, developed what was believed to have been a sore throat, and had problems with neck control.

On April 10, the minor's temperature was somewhat lower but was not normal. On April 11, because father had a scheduled meeting, the baby was somewhat better, and father had arranged for his brother to stay at the Sunnyvale apartment to help out, father left for work in San Francisco. He missed the call at work later that the minor had been taken to the hospital. When father heard the news, he took the first train available to Sunnyvale.

When Dr. Albin met mother and father in the hospital on April 11, she explained to them that that the "brain clots" shown on the MRI were the type of injuries caused by a great deal of force, such as the head going back and forth in a motor vehicle accident. Dr. Albin also asked parents if they were familiar with the term "shaken baby syndrome," and demonstrated the force a baby head moving back and forth would be subjected to, asking whether parents had done that. Father testified that he and mother described normal activities—such as the minor's being rocked back and forth in a baby swing and being driven in a very hilly area of San Francisco—to explore with Dr. Albin whether they could account for the injuries. Dr. Albin responded that these were normal activities that would not have caused the minor's injuries. Father explained that he and mother

"were in a total shock" hearing what Dr. Albin told them and seeing their baby sedated, ill and having experienced a spinal tap. He said there was a feeling of "helplessness" in which they were happy that the minor was receiving the medical attention he needed, "[a]nd at the same time, knowing the people we are, knowing each other, and the things [Dr. Albin] was explaining, it is . . . like another universe. . . . [T]he things she was explaining, could have never happened and did not happen."

Father testified that the maternal grandmother, J.M., fainted at the hospital on the evening of April 11. After the hospital made sure that J.M. was stable, parents decided that, since it was 8:30 or so in the evening, it would be best to have father stay and for mother to go home with the grandparents, since they had been at the hospital since the morning.

Father testified that he had never shaken the minor. Father had spoken with mother on April 12 and had asked whether she had ever shaken the minor; she denied it. Father had also asked the maternal grandparents on April 12 if either of them had shaken the baby and they denied it. Father testified that both he and mother were always very attentive and affectionate with the minor. They understood that because the minor had a premature birth, they needed to be very careful with him. Father also denied that mother was ever depressed or unhappy at any time following the minor's birth.

Father believed the minor's condition on April 11, was due to several factors, including his having been born premature through a very difficult delivery. In addition, Father testified that he and mother had seen symptoms early in the minor's life where there were occasionally times that the minor's eyes did not seem to be "focused." Additionally, the minor had been sick four to five days before April 11. Father also believed there was a possibility that the vaccinations the minor received and the fact that he had a large head circumference may have played some role in his injuries.

b. Testimony of Mother

Mother testified she had a difficult delivery, as described in her husband's testimony. During delivery, the obstetrician was required to make adjustments because the minor's head was not lined up with the birth canal.

Mother acknowledged that in a January 27 questionnaire, she had stated she felt down, depressed or hopeless more than half the days in the previous two-week period. She explained that this feeling had been due to skin rashes that she had at the time; the problem resolved after about two weeks.

Mother testified that no one had violently shaken the minor in the manner she understood would have been required to have caused the minor's claimed injuries. She denied that she had ever acted aggressively toward the minor out of frustration. Mother testified that her parents were very patient with the minor and that father was very good with him.

c. Testimony of Dr. Archana Kayastha

Dr. Archana Kayastha is a board-certified pediatrician working for Kaiser Permanente. She performed the first well-check examination of the minor on January 9. As of the date of the hearing, Dr. Kayastha was the minor's pediatrician. During the first well-check visit, parents expressed concern regarding feeding issues and with the minor "being a little jaundiced," and they had general questions regarding taking care of the minor, who was their first child. Dr. Kayastha found parents to be conscientious with respect to their questions about the minor.

Dr. Kayastha treated the minor for a second-month visit on March 3. Generally at this appointment, the infant receives immunizations. There was nothing presented at either the first or second appointment that caused Dr. Kayastha to have any concern about the care the minor was receiving.

During office visits, Dr. Kayatha routinely screened for postpartum depression; this included having the mother complete a questionnaire and Dr. Kayatha speaking with

the mother. In this case, nothing presented itself during the January 9 visit that raised a concern about mother's possible depression. In the March 3 visit, a score of two was calculated from mother's responses to the questionnaire; Dr. Nayastha testified that if the score is greater than two, "we kind of become more aggressive in addressing postpartum depression." She did not recall whether she inquired of mother concerning any depression at the March 3 visit.

Based upon the two office visits and a third office visit after the minor was discharged from the hospital, Dr. Kayastha concluded that this was a family in which parents had bonded with the minor.

d. Testimony of Kelly Kichak

Kelly Kichak is a pediatric ICU nurse who treated the minor after his hospitalization on April 11. During the time that she was on-shift, Kichak found mother to have been "very attentive, very worried about what was going on." Kichak also observed father's interactions with the minor, although he was not at the hospital as often as mother. Kichak found father to be attentive and observed that he played with the minor.

e. Testimony of Dr. Stephen Gabaeff

Dr. Stephen Gabaeff is an emergency room physician who practiced in that capacity from 1976 to 2011. In 1988, he began to work in a parallel profession as a clinical forensic medical specialist. As an expert witness for mother, the court qualified Dr. Gabaeff to testify as to his opinions concerning the diagnoses that were made relative to the minor and whether or not child abuse existed.

Dr. Gabaeff testified that the minor, under the circumstances, had an 84 percent chance of sustaining a perinatal subdural hematoma. From his review of the labor and delivery records, Dr. Gabaeff stated that the minor had likely suffered a subdural hematoma at birth and there was a possibility that rebleeding occurred later so that "this perinatal subdural hematoma evolved into a chronic subdural and was relatively stable."

Dr. Gabaeff opined that there was no evidence of brain injuries occurring over several different times; the only traumatic event was the perinatal subdural hematoma. He testified that on April 6, the minor became sick and he was taken to the emergency room on April 7, where it was determined that he "had a positive urinary tract infection with 50[,000] to 100,000 colonies of E. coli."[8] The minor was prescribed Keflex, which Dr. Gabaeff explained was ineffective, and the minor developed sepsis; the urinary tract infection spread into the blood and into the dura, resulting in the onset of meningitis. The minor had seizures, which are a common result of the meningitis. Dr. Gabaeff opined that "[t]here was no evidence of any abuse at any time in any aspect of the case, including imaging and the clinical history, the social history, and the findings themselves, where were all 100 percent consistent with E. coli meningitis, and that's all."[9]

Dr. Gabaeff reviewed the minor's MRI imaging in consultation with two radiologists. Dr. Susan Gootnick was one of those consulting radiologists. Dr. Gabaeff opined that the imaging did not demonstrate signs of acute blood; the imaging showed "no significant amounts of acute blood relative to what one would expect with a traumatic subdural hemorrhage." He testified that the imaging showed that there was an empyema—an empyema being similar to a boil or a mass of pus similar to an abscess that occurs on the skin—in the subdural portion of the minor's head, caused by the progression of the E. coli meningitis. Dr. Gabaeff stated that the empyema is a known

[8] Dr. Gabaeff corrected this testimony on cross-examination, stating that the medical records showed that the bacteria count from the minor's urine sample was 10,000 to 50,000 colonies of E. coli.

[9] Dr. Gabaeff dismissed Dr. Albin's opinion that the minor suffered a brain shear, stating that the concept of brain shearing injuries is a "hypothesis" which he does not believe to be valid.

complication of E. coli meningitis,[10] and it developed in the minor here due to a lack of treatment of the E. coli meningitis.

f. Testimony of Dr. Susan Gootnick

Dr. Susan Gootnick is a radiologist who has been in practice approximately 43 years. As an expert witness for mother, the court qualified Dr. Gootnick to testify in the field of radiology regarding her opinions concerning the MRI films involving the minor and her evaluation of those films.

Dr. Gootnick concluded the minor's cranial MRI scans showed that he had chronic subdural hematomas, and an empyema in the left hemisphere (represented by a "darker white" area in the film). She described an empyema as a collection of "white blood cells called pus" resulting from the body's attempt to fight off an infection and related to the minor's meningitis. She opined that the chronic subdural hematomas had probably existed since birth. This opinion was based upon her conclusion that the medical records showed the minor "had a terrible delivery, very traumatic," including the fact that the baby's head had not lined up with the birth canal. Dr. Gootnick also observed "a little tiny black area" that represented blood from the empyema; its presence was related to the minor's meningitis.

Dr. Gootnick did not observe any acute subdural hematomas; they would have been evidenced by black areas in the film representing blood.[11] Dr. Gootnick testified further that there is generally cervical cord damage when there is a traumatic subdural hematoma because of the force required to sustain the injury; no such cervical cord

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[10] Dr. Gabaeff explained on cross-examination that the frequency of an infant developing an empyema from E. coli meningitis "is relatively low, but it's a very serious complication."

[11] Dr. Gootnick acknowledged on cross-examination that the small amount of blood from the empyema constituted an acute subdural hemorrhage, but that it was "[n]ot a clinically significant one."

damage was presented in the minor's MRI films. She disagreed with Dr. Albin's opinion that there were multiple-aged subdural hematomas supporting a diagnosis of nonaccidental trauma; Dr. Gootnick testified that "[t]here is no radiological support for that information."

Dr. Gootnick also concluded from the MRI scans, and based upon the absence of small black areas that would evidence blood, that the minor had not sustained a shearing injury in the occipital lobes of the brain. She testified that brain shearing is a real injury, but that its causes are "up for debate." Acceleration and deceleration can cause shearing, but a large amount of force is required.

3. Department's Rebuttal Evidence

a. Testimony of Dr. Ramin Saket

Over mother's objection, the Department called Dr. Ramin Saket as a rebuttal expert witness. He is affiliated with Permanente Medical Group. Dr. Saket is a radiologist and a board-certified neuroradiologist for which completion of a two-year fellowship was required. Neuroradiology "focuses on the brain, the head and neck, the spine, and the peripheral nerves." As of the time of the hearing, Dr. Saket had been involved in the subspecialty of pediatric neuroradiology for eight years; he came to Kaiser Santa Clara to establish the pediatric neuroradiology program. The court qualified Dr. Saket as an expert "to give an opinion in pediatric neuroradiology as it relates to rebutting . . . Dr. Gootnick's opinion, as to the foundation of her opinion . . . . [H]is testimony would be limited to that."

Dr. Saket read the minor's cranial MRI scans, prepared a report, and reported his findings to Dr. Albin. He opined at the hearing that the MRI scans showed a chronic subdural hematoma in the upper left side of the brain to "[a] hundred percent certainty." Dr. Saket disagreed with the testimony of Dr. Gootnick that the MRI scans showed only an empyema and not a subdural hematoma with acute blood on the left side of the brain. He explained: "[T]hat doesn't mean there isn't an empyema. There can be a

superimposed empyema. But to say it's only empyema and that there's no hemorrhage is incorrect." From the MRI films, Dr. Saket testified that there was "something superimposed [on the chronic subdural hematoma] that ha[d] very recently acutely occurred." He believed the fluid seen on the left side was acute blood, pus, or a combination of acute blood and pus. Dr. Saket testified that, because there was more definitive evidence of acute blood in the subarachnoid space, this made it more likely there was blood in the subdural space as well.

The left-side chronic subdural hematoma was, in Dr. Saket's opinion, not related to the minor's birth. He stated that "bleeds that cause membranes and cause persistent collections . . . [were] not . . . normal birth-related sub[dural] hematomas. That's caused from repetitive bleeding." Dr. Saket opined that if a child sustained a small subdural hematoma at birth—regardless of whether the delivery was routine or had complications—the subdural hematoma would resolve in one to two months.

Dr. Saket testified that he believed there was a second chronic subdural hematoma that was located on the right side of the minor's brain. He stated it was "certainly the most likely possibility," but the condition in the area in question could "be a subdural effusion."

The MRI scans also showed "bilateral subdural fluid collections." These collections on both sides of the minor's brain would not normally be present in the brain of a healthy three-month-old infant.

Dr. Saket also testified that there was evidence of brain shear injury, defined as damage to the structure of the brain. He explained there can be damage at the junction of brain matter and white matter compartments of the brain when the "two compartments . . . slide past one another and, essentially, break their connection." When this occurs, it is often evidenced by small spots of bleeding at the sites of the breakage. Here, the MRI films showed a black dot "at the white matter junction of the cerebellum" on the left side of the brain that represented the focus of the hemorrhage. The black dot

in the brain tissue would not be present in a normal, healthy child. He testified that in a follow-up MRI scan of the minor, evidence of "the multiple sites of hemorrhagic shear injury in the cerebellum [were] still there"; he would not have expected a resolution of the injuries to appear in the follow-up scan. Dr. Saket opined that, while not "100 percent," his conclusion was that the black dot in the cerebellum more likely than not represented hemorrhagic shearing injury. He testified further that an infection could not cause this type of bleeding in the cerebellum.

In addition, Dr. Saket said there was shearing evidenced by some acute blood in the subarachnoid space on the left side of the brain. He described it as a shearing injury to blood vessels which is "highly correlated with traumatic injury, usually from acceleration/de[]celeration." The bleeding in the subarachnoid space, Dr. Saket opined, would have occurred within one week of April 11.

Based upon questioning by the court, Dr. Saket testified that when he prepared his report on his findings concerning the MRI scans, he did not know that the minor had meningitis; he became aware the minor had the infection approximately one month after preparing the report. He explained that without signs or a diagnosis of an existing infection, in interpreting the MRI results, he concluded it to be much more likely that there was acute blood present in the subdural area of the left side of the brain. Viewing the matter retrospectively, knowing there was an infection, he would not make the conclusion that it was simply acute blood, but would state that " '[t]his could be pus or acute blood.' " He reiterated, however, that there were "signs of blood in [the] subarachnoid space." Dr. Saket opined that, even with the later knowledge that the minor had meningitis on April 11, the minor definitely had "blood in the brain from preexisting chronic injury." Dr. Saket testified further that meningitis would not have caused the chronic subdural hematoma, the subarachnoid hemorrhages, or the shearing injury.

4. Denial of Surrebuttal Evidence

As discussed in detail, *post*, near the conclusion of the hearing and after the completion of Dr. Saket's testimony, mother requested leave to present surrebuttal evidence. She requested permission to call Dr. Patrick Barnes, the medical director chief of pediatric neuroradiology at Lucille Packard Children's Hospital, as an expert witness to respond to the rebuttal testimony of Dr. Saket. Mother's counsel made an offer of proof that Dr. Barnes would provide testimony to rebut Dr. Saket's opinions that (1) there were hemorrhages of different ages (and Dr. Barnes would counter that the MRI showed only an enhancement of the meninges caused by meningitis); (2) bleeding in the subarachnoid space was not caused by meningitis, and (3) dots Dr. Saket identified in the MRI scans represented a brain shear injury. After argument and submission of the issue, the court denied mother's request. Mother moved to strike Dr. Saket's testimony; the juvenile court denied the motion to strike.

5. Court's Decision

At the conclusion of the hearing, and after extensive argument, the juvenile court submitted the case so that it could review the entire matter; it set a further hearing 13 days later. At the further hearing on August 3, the juvenile court found by a preponderance of the evidence that the allegations of the amended petition were true, concluding the minor was a child described by subdivisions (a), (b), and (e) of section 300. In so concluding, the court found under section 355.1, subdivision (a)[12] that the Department had made a prima facie showing that the minor was a child described under section (a) and (b) of section 300 by presenting competent professional evidence

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[12] "Where the court finds, based upon competent professional evidence, that an injury, injuries, or detrimental condition sustained by a minor is of a nature as would ordinarily not be sustained except as the result of the unreasonable or neglectful acts or omissions of either parent, the guardian, or other person who has the care or custody of the minor, that finding shall be prima facie evidence that the minor is a person described by subdivision (a), (b), or (d) of Section 300." (§ 355.1, subd. (a).)

that the minor's injury would not have been sustained without the unreasonable or neglectful acts of parents.[13] It "found Dr. Albin's testimony to [have been] thorough, credible and reliable[, having] . . . worked with a multi-disciplinary team which included radiologist Dr. [Ramin] Saket to diagnose and treat [the minor]." The court, having found the Department had made a prima facie showing under section 355.1, subdivision (a), reasoned that parents were required to raise an issue as to the actual cause of the minor's injuries. The juvenile court found the testimony of mother's two expert witnesses, Dr. Gabaeff and Dr. Gootnick, to have lacked credibility and persuasiveness, and it concluded that parents had failed to show any reasonable explanation for the minor's injuries.

D. Disposition Hearing

The Department recommended in a supplemental trial brief and second addendum report concerning disposition that the juvenile court remove the minor from the custody and care of parents and order that family reunification services be provided to parents. The Department reported that the minor was discharged from the hospital on May 2. As of May 25, the minor was being cared for in the home of the paternal uncle, with assistance from the paternal grandmother who traveled from India to assist in caring for the minor. The minor's health had improved under the care of the paternal relatives. The paternal uncle signed a concurrent home agreement indicating his willingness to adopt the minor should parents not be able to reunify with the minor. The Department reported further that since the court issued an order on May 11 for supervised visitation three

[13] The record reflects that the court made a finding, pursuant to section 355.1, subdivision (a), that the Department had made a prima facie showing that the minor was a child "within the meaning of Welfare and Institutions Code section 300 (a) and (b) *and (d)*." (Italics added.) Because the amended petition contained no allegations under subdivision (d) of section 300, and that subdivision is clearly not applicable, we will disregard this reference in the record.

times per week, two hours per visit, parents had consistently visited the minor and the visits had gone well.

The juvenile court conducted a disposition hearing on August 23. The court received into evidence materials submitted by the parties, including the Department's disposition report and its first and second addenda thereto, and mother's submissions consisting of visitation observation reports, home visit summaries, mother's certificates of completion concerning parent orientation and parenting without violence programs, and a discovery packet of materials. The court, inter alia, (1) adjudged the minor to be a dependent child; (2) found by clear and convincing evidence that it was required that the minor be removed from the physical custody of parents because there was or would be substantial danger to the physical health, safety, protection, or physical or emotional well-being of the minor if he were returned to the home, and there were no reasonable means to protect the minor's physical health without such removal from the home; (3) ordered that parents receive reunification services; and (4) approved a case plan that included parents' completion of parent orientation class, parenting without violence class, an educational program concerning child brain injuries and their causes, long-term effects, and their prevention, enrollment in an infant parenting support group, weekly counseling, and (for mother) a postpartum depression evaluation; (5) ordered placement to remain with the approved home of a relative, the paternal uncle; and (6) ordered visitation for parents supervised by the paternal uncle of a minimum of five times per week for a minimum of two hours per day.[14] The court set a review hearing for October 11.

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[14] The clerk's minutes do not specifically reflect that the disposition hearing was a contested proceeding. But the record reflects that there were discussions between counsel and the court in which the court indicated its tentative conclusion that, based upon the evidence it had received in the jurisdiction hearing and the submissions by the Department in connection with the disposition hearing, it was not inclined to grant mother's request that the minor be returned to the home. Mother's counsel submitted

Mother and Father filed timely notices of appeal from the court's disposition order. (See *In re Candida S.* (1992) 7 Cal.App.4th 1240, 1249 [true findings as to jurisdictional allegations are appealable from order after dispositional hearing].)[15]

E. Subsequent Developments

During briefing on appeal, certain relevant developments occurring after the jurisdiction and disposition hearings were brought to the attention of this court by the Department. At the six-month review hearing on February 21, 2018, the court ordered the minor returned to the care, custody, and control of parents with family maintenance services. At an interim hearing on June 18, 2018 (when the minor was approximately 18 months old), the court issued an order terminating the dependency.[16]

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additional evidence concerning visitation and parents' completion of certain classes, which the court considered, and it advised counsel that it was still not inclined to order the minor's return to parents, but it felt reunification services were appropriate.

[15] Mother's and father's respective notices of appeal refer to a number of different orders of the juvenile court from which they purportedly appeal. The orders referenced by both parents are ones dated May 8, May 11, May 23, May 30, June 19, June 26, July 5, July 7, July 10, July 11, July 12, July 13, July 14, July 17, July 18, July 19, July 20, July 21, August 23, and October 11. Mother also references in her notice of appeal orders dated April 14, August 3, and October 11. "[T]he dispositional order is the adjudication of dependency and is the first appealable order in the dependency process. [Citations.]" (*In re Sheila B.* (1993) 19 Cal.App.4th 187, 196.) In general, jurisdictional findings and other pre-disposition orders are reviewable in the appeal of the disposition order. (*In re M.C.* (2011) 199 Cal.App.4th 784, 801.) Additionally, father filed a separate notice of appeal from the court's order of October 11. The October 11 order, being one occurring after the disposition order, was an appealable order. (*Dwayne P. v. Superior Court* (2002) 103 Cal.App.4th 247, 259.) Since parents do not present any argument specifically concerning any orders that predated the jurisdiction hearing or that postdated the disposition hearing, they have forfeited any challenge to such orders. (*In re Marriage of Falcone & Fyke* (2008) 164 Cal.App.4th 814, 830.)

[16] Although the juvenile court terminated its dependency jurisdiction in this case, that act does not moot parents' respective appeals. The court's jurisdictional findings, if erroneous, could have significant future adverse consequences upon parents, including the court's jurisdictional finding under section 300, subdivision (e) that the minor suffered severe physical abuse by a parent or by a person known to the parent, and the parent knew or reasonably should have known that the person was abusing the minor.

II. DISCUSSION

A. Applicable Law

1. Dependency Proceedings

Section 300 et seq. provides "a comprehensive statutory scheme establishing procedures for the juvenile court to follow when and after a child is removed from the home for the child's welfare. [Citations.]" (*In re Celine R.* (2003) 31 Cal.4th 45, 52.) As our high court has explained, "The objective of the dependency scheme is to protect abused or neglected children and those at substantial risk thereof and to provide permanent, stable homes if those children cannot be returned home within a prescribed period of time. [Citations.] Although a parent's interest in the care, custody and companionship of a child is a liberty interest that may not be interfered with in the absence of a compelling state interest, the welfare of a child is a compelling state interest that a state has not only a right, but a duty, to protect. [Citations.] The Legislature has declared that California has an interest in providing stable, permanent homes for children who have been removed from parental custody and for whom reunification efforts with their parents have been unsuccessful. [Citations.] This interest is a compelling one. [Citation.]" (*In re Marilyn H.* (1993) 5 Cal.4th 295, 307.)

The court at the jurisdiction hearing must first determine whether the child, by a preponderance of the evidence, is a person described under section 300 as coming within the court's jurisdiction. (§ 355, subd. (a); see *Cynthia D. v. Superior Court* (1993) 5 Cal.4th 242, 248.) The agency bears the burden of proving the allegations of the petition. (*In re Matthew S.* (1996) 41 Cal.App.4th 1311, 1318.)

The juvenile court may sustain the allegations of a petition under subdivision (a) of section 300 (as alleged here)—i.e., that "[t]he child has suffered, or there is a

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(See *In re Daisy H.* (2011) 192 Cal.App.4th 713, 716; see also § 361.5, subd. (b)(3) [juvenile court may deny reunification services to parent, inter alia, if there was prior adjudication of dependency involving the child or sibling of child].)

substantial risk that the child will suffer, serious physical harm inflicted nonaccidentally upon the child by the child's parent or guardian" (*ibid.*)—even if the cause of the child's injuries are unknown or "[t]he conclusive identity of the perpetrator" is not determined. (*In re A.S.* (2011) 202 Cal.App.4th 237, 245.) As that court explained: "The prerequisite of a conclusive identification could lead to absurd results, the potential return of a seriously injured child to an unidentified perpetrator. The purpose of dependency law 'is to provide maximum safety and protection' for currently abused and neglected children and to ensure the safety of children at risk of harm. [Citation.]" (*Id.* at pp. 245-246.) Likewise, where it is alleged that the child is one described as a dependent child under subdivision (e) of section 300 (as was alleged here)—namely, a child less than five years old who "has suffered severe physical abuse by a parent, or by any person known by the parent, if the parent knew or reasonably should have known that the person was physically abusing the child" (*ibid.*)—the fact that "there is no identifiable perpetrator, only a cast of suspects, . . . [does] not automatically rule[] out" jurisdiction under subdivision (e). (*In re E.H.* (2003) 108 Cal.App.4th 659 670.) And under that subdivision, where the evidence shows that the parent reasonably should have known that the child was being physically abused by someone in the household, that is sufficient for a jurisdictional finding under section 300, subdivision (e), irrespective of whether the parent had *actual* knowledge of the abuse. (*In re E.H., supra*, at p 670.)

If there is a jurisdictional finding made, i.e., that the child is a person described in section 300, at a dispositional hearing, the juvenile court must hear evidence to decide the child's disposition (§ 358, subd. (a)), i.e., whether he or she will remain in, or be removed from, the home, and the nature and extent of any limitations that will be placed upon the parents' control over the child, including educational or developmental decisions. (§ 361, subd. (a)(1).) If at the dispositional hearing, the court determines that removal of the child from the custody of the parent or guardian is appropriate, such removal order must be based upon clear and convincing evidence establishing that one of the statutory

circumstances exists. (*Id.*, subd. (c).) One such circumstance is the existence of substantial danger to the dependent child's "physical health, safety, protection, or physical or emotional well-being" were he or she returned to the home. (*Id.*, subd. (c)(1).)

2. Standard of Review

As discussed below, the challenge on appeal is based upon the juvenile court's exclusion of evidence from a surrebuttal expert witness proposed by parents. As an alternative to their argument that the court erred in excluding this evidence, parents contend the juvenile court erred in refusing to strike the testimony of the Department's rebuttal expert, Dr. Saket.

A trial court's decision to admit or exclude evidence is reviewed on appeal for abuse of discretion. (*Christ v. Schwartz* (2016) 2 Cal.App.5th 440, 446.) Likewise the court's admission or exclusion of rebuttal or surrebuttal evidence is reviewed for abuse of discretion. (*Kelly*, *supra*, 51 Cal.3d at p. 965 [rebuttal evidence]; *Lamb*, *supra*, 136 Cal.App.4th at p. 582 [surrebuttal evidence].) And a trial court's decision regarding the admissibility of expert witness testimony is subject to the deferential abuse of discretion standard of review. (*Rappaport v. Gelfand* (2011) 197 Cal.App.4th 1213, 1229.)

"An abuse of discretion occurs when the juvenile court has exceeded the bounds of reason by making an arbitrary, capricious or patently absurd determination. [Citation.]" (*In re Marcelo B.* (2012) 209 Cal.App.4th 635, 642, quoting and citing *In re Stephanie M.* (1994) 7 Cal.4th 295, 318.) These broad principles notwithstanding, an appellate court is not limited to reversing a trial court for abuse of discretion only if "its action was utterly irrational." (*City of Sacramento v. Drew* (1989) 207 Cal.App.3d 1287, 1297.) A trial "court's discretion is not unlimited, especially when . . . its exercise implicates a party's ability to present its case. Rather, it must be exercised within the confines of the applicable legal principles." (*Sargon Enterprises, Inc. v. University of Southern California* (2012) 55 Cal.4th 747, 773.) And as the high court has further

explained: " 'The discretion of a trial judge is not a whimsical, uncontrolled power, but a legal discretion, which is subject to the limitations of legal principles governing the subject of its action, and to reversal on appeal where no reasonable basis for the action is shown.' [Citations.] 'The scope of discretion always resides in the particular law being applied, i.e., in the "legal principles governing the subject of [the] action. . . ." Action that transgresses the confines of the applicable principles of law is outside the scope of discretion and we call such action an "abuse" of discretion. [Citation.] . . . [¶] The legal principles that govern the subject of discretionary action vary greatly with context. [Citation.] They are derived from the common law or statutes under which discretion is conferred.' [Citation.] To determine if a court abused its discretion, we must thus consider 'the legal principles and policies that should have guided the court's actions.' [Citation.]" (*Ibid.*)

B. Surrebuttal Testimony of Dr. Barnes Should Have Been Admitted

Our review of the court's ruling denying parents leave to present surrebuttal expert testimony from Dr. Barnes involves several tasks. We will (1) describe the proceedings in the juvenile court below in which mother's counsel requested leave to present surrebuttal testimony of Dr. Barnes and made an offer of proof of such testimony, and in which the court, after hearing argument, denied the request; (2) identify the applicable legal principles of rebuttal and surrebuttal testimony; (3) summarize the medical expert testimony presented as an aid to our analysis; and (4) consider whether exclusion of the rebuttal testimony was error in light of (a) parents' right to procedural due process and the right to present evidence, (b) the scope of Dr. Saket's testimony as a rebuttal witness, (c) the nature of Dr. Barnes's proposed surrebuttal testimony, and (d) the potential significance of the excluded evidence.

1. Background

Near the conclusion of the hearing, counsel for mother, Peter Johnson, requested leave to present an expert witness on surrebuttal to respond to the rebuttal testimony of

Dr. Saket. Johnson identified this potential witness as Dr. Patrick Barnes, the medical director chief of pediatric neuroradiology at Lucille Packard Children's Hospital Stanford and a researcher with the Child Development & Research Institute. Johnson represented to the court that Dr. Barnes had "done about 185 different peer-reviewed and published articles on the subject matter of pediatric neuroradiology" and was "one of the world[-]renowned experts in his field." Father's counsel joined in mother's request to permit the surrebuttal expert testimony of Dr. Barnes.

Mother's counsel made an offer of proof concerning Dr. Barnes's proposed testimony.[17] Johnson stated that Dr. Barnes would respond to Dr. Saket's opinion that there were "different aged bleeds within th[e] chronic subdural hematoma" with the opinion that there was "just an enhancement of the meninges . . . [rather than] different components of that subdural hematoma."[18] Johnson represented that Dr. Barnes would also respond to Dr. Saket's testimony concerning bleeding in the subarachnoid space and Dr. Saket's conclusion that meningitis was not the cause of the subarachnoid bleeding or the membranes Dr. Saket identified. It was represented that Dr. Barnes would also respond to Dr. Saket's opinion that a "couple of dots that he identified" in the MRI scans represented a brain shear injury.

Johnson argued that Dr. Barnes's surrebuttal expert testimony should be permitted. Johnson argued that Dr. Saket was not a proper rebuttal expert. Johnson stated that the Department had made a choice of using Dr. Albin as its medical expert and had not called Dr. Saket in its case-in-chief. After the Department rested, the court, over Johnson's objection, permitted the Department to call Dr. Saket as a rebuttal expert when in fact he

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[17] We have attempted to recite the offer of proof by attorney Johnson concerning Dr. Barnes's proposed testimony with clarity from our review of the record.

[18] At the next day of the hearing, Johnson explained further that Dr. Barnes would testify that "[t]he meningitis is the reason why you have those membranes there."

was not offering rebuttal testimony but was reiterating the Department's original medical opinion testimony.

Mother's counsel also argued that Dr. Barnes should be permitted to testify because Dr. Saket provided new information in his testimony that Johnson could not have anticipated. Johnson identified three new matters. First, although it was recited in the reports from the MRI scans available before the hearing that there was an "acute subdural hematoma on a subacute subdural hematoma on a chronic subdural hematoma [*sic*]," Dr. Saket contradicted that there were either acute or subacute subdural hematomas. Second, although the MRI report noted brain shearing, it contained no explanation about the "two little remote dots" to which Dr. Saket referred in his testimony and which he stated evidenced brain shear injury. Third, mother's counsel argued that Dr. Saket's testimony concerning meningitis was new because he had not addressed meningitis when he had prepared his report on the MRI scans.

The Department objected to the proposed surrebuttal testimony. It asserted that Dr. Saket's reports were made available prior to the hearing and that the proposed testimony by Dr. Barnes involved matters that were covered in Dr. Saket's reports. The Department argued that the proposed testimony therefore did not involve new evidence from a rebuttal witness that was a proper subject of surrebuttal testimony.

After argument and submission of the issue, the court denied mother's request to call Dr. Barnes as a surrebuttal expert. Mother's counsel, Johnson, filed a motion to strike the testimony of Dr. Saket as a rebuttal expert. He argued, inter alia, that Dr. Saket "did not provide rebuttal evidence; his testimony was sought to further the [Department's] case in chief." He argued that mother's due process rights had been violated because the court had permitted the Department to call Dr. Saket as a rebuttal expert without permitting mother to rebut that testimony. After hearing argument, the juvenile court denied mother's motion to strike Dr. Saket's testimony.

2. Rebuttal and Surrebuttal Evidence

After the parties have presented their respective cases in chief, they may present rebuttal evidence unless the court, for good cause, permits the parties to offer additional evidence on their original respective cases. (Code Civ. Proc., § 607, subd. (6); see also Pen. Code, § 1093, subd. (d).) Rebuttal evidence presented by the plaintiff is appropriate to address affirmative evidence introduced by the defendant in its case-in-chief. (*Charleville v. Metropolitan Trust Co. of Cal.* (1934) 136 Cal.App. 349, 360 (*Charleville*), disapproved on other grounds by *Stowe v. Fritzie Hotels* (1955) 44 Cal.2d 416, 424; see also *Ray v. Jackson* (1963) 219 Cal.App.2d 445, 454 [personal injury plaintiff properly allowed to testify further on rebuttal after defendant raised new matters in his case-in-chief].) Similarly, in criminal cases, rebuttal evidence presented by the prosecution is appropriate if it "tend[s] to disprove a fact of consequence on which the defendant has introduced evidence. [Citation.]" (*People v. Wallace* (2008) 44 Cal.4th 1032, 1088.) " '[T]he scope of rebuttal must be specific.' " (*People v. Loker* (2008) 44 Cal.4th 691, 715.)

A party may not withhold evidence that should have been offered in his or her case-in-chief to submit it in rebuttal to his or her adversary's case; this is not in the nature of rebuttal evidence. (*Lipman v. Ashburn* (1951) 106 Cal.App.2d 616, 620 (*Lipman*) [evidence that driver of defendant's truck failed to stop at intersection was part of plaintiff's case-in-chief and not properly withheld for rebuttal]; see also *Augenthaler v. Pinkert* (1934) 138 Cal.App. 455, 458-459 [testimony as to whether witness saw automobile strike pedestrian was properly excluded as improper rebuttal, since its subject-matter was part of plaintiff's case-in-chief].) Likewise, "proper rebuttal evidence does not include a material part of the case in the prosecution's possession that tends to establish the defendant's commission of the crime. It is restricted to evidence made necessary by the defendant's case in the sense that he [or she] has introduced new

evidence or made assertions that were not implicit in his denial of guilt. [Citations.]" (*People v. Carter* (1957) 48 Cal.2d 737, 753-754 (*Carter*).)

Surrebuttal evidence may be presented by the defendant in response to rebuttal evidence presented by the prosecution/plaintiff. (See *People v. Avila* (2014) 59 Cal.4th 496, 504.) But surrebuttal by a defendant is proper "to rebut *only new* matter educed by the People." (*People v. Remington* (1925) 74 Cal.App. 371, 376, original italics.) And the scope of surrebuttal evidence may be restricted by the trial court to prevent introduction of repetitive matter that should have been presented by the defendant in his or her case-in-chief. (*Lamb, supra,* 136 Cal.App.4th at p. 582.) Thus, where the defendant in an action to recover under an insurance policy offered testimony in surrebuttal concerning the condition of the streets at the time of the accident, the evidence was properly refused, since that subject matter was part of the defendant's case-in-chief. (*California Wine Ass'n.l, v. Commercial Union Fire Ins. Co. of New York* (1910) 159 Cal. 49, 56.)

3. Summary of Medical Testimony

As the issues in this appeal turn on an understanding of the complex medical expert testimony presented at the jurisdiction hearing, we present a brief summary of that testimony as a preface to discussing parents' claims of error.

The Department's expert and the minor's treating physician, Dr. Catherine Albin, based her opinions upon her examination and testing of the minor (including cranial MRI and spinal taps), in conjunction with multidisciplinary consultations with her colleagues. She opined that the minor presented with multiple subdural hematomas that were acute, subacute, and chronic. Dr. Albin concluded there had been at least three traumatic events, and that the most recent one had occurred within 24 hours of the minor's April 11 admission at Kaiser Santa Clara where he presented with seizures and acute bleeding. She stated that the meningitis disclosed from the results of the first spinal tap was of very recent origin and was not the cause of the minor's subdural bleeding. Dr. Albin also

opined that the minor had a shearing injury to the brain itself, one which is commonly associated with an acceleration-deceleration injury.

Dr. Albin's opinion was that the multiple subdural hematomas of different ages, brain shearing, and acute blood in the CSF were consistent with multiple episodes of abusive head trauma caused by rapid acceleration and deceleration. She concluded that the minor suffered traumatic injury based upon rapid acceleration and deceleration because (1) the minor presented with subdural hematomas of three different ages, (2) the minor had a brain shearing injury, (3) there was no plausible explanation from parents for the injuries, (4) the minor's injuries were ones that did not naturally happen, and (5) there was no alternative medical explanation for the injuries.

Dr. Stephen Gabaeff, mother's emergency room physician and forensic medical expert, testified that the minor had likely suffered a subdural hematoma at birth and there was a possible rebleeding at a later time, resulting in "a chronic subdural [that] was relatively stable." He opined that there was no evidence of brain injuries occurring over several different times, and the perinatal subdural hematoma was the only traumatic event. The MRI films showed no evidence of acute blood; there were only subdural empyemas, caused by the progression of E. coli meningitis. Dr. Gabaeff testified there was no brain shearing injury. He concluded "[t]here was no evidence of any abuse at any time."

Dr. Susan Gootnick, mother's radiologist expert, testified that the minor presented with chronic subdural hematomas and a left-hemisphere empyema. The empyema resulted from an attempt by the minor's body to repel the infection related to the minor's meningitis. She opined that the chronic subdural hematomas had probably existed since the minor's birth. Dr. Gootnick also testified that the very small black area on the MRI imaging was blood from the empyema that was related to the meningitis. She found no acute subdural hematomas in the imaging. Dr. Gootnick also concluded that the minor had not sustained a shearing injury in the occipital lobes of the brain.

Dr. Ramin Saket, the Department's rebuttal neuroradiologist expert who read and reported on the minor's MRI scans, opined that they showed to a certainty a chronic subdural hematoma in the upper left side of the brain. He opined that the left-side chronic subdural hematoma was not related to the minor's birth. Dr. Saket testified further that there was acute blood, pus, or a combination of acute blood and pus superimposed on the chronic left-side subdural hematoma, and that the fluid showed that something "ha[d] very recently acutely occurred." And he disagreed with Dr. Gootnick's testimony that the MRI scans showed only an empyema and not a subdural hematoma with acute blood. Dr. Saket testified that he believed the minor had a second, right-side, chronic subdural hematoma.

Dr. Saket testified further that there was evidence of shearing injury on the left side of the minor's brain, shown as a black dot representing bleeding "at the white matter junction of the cerebellum" on the left side of the brain that represented the focus of the hemorrhage. He testified that a brain shear injury was also evidenced by some acute blood in the subarachnoid space on the left side, which was "highly correlated with traumatic injury, usually from acceleration/de[]celeration." Dr. Saket opined that this bleeding would have occurred within one week of April 11.

Dr. Saket testified that he had been unaware that the minor had meningitis when he had prepared his report on the MRI findings. Based upon this after-acquired information, he revised his conclusion that there was a strong likelihood that the fluid in the left-side subdural hematoma was acute blood; with the knowledge of an existing infection, Dr. Saket concluded that " 'this could be pus or acute blood.' " Dr. Saket opined further that meningitis would not have caused the chronic subdural hematomas, the subarachnoid hemorrhages, or the shearing injury presented in the minor's MRI results.

4. Exclusion of Surrebuttal Testimony

The Supreme Court, in "[d]escribing a party's fundamental right to present evidence at trial in a civil case," has explained: " 'One of the elements of a fair trial is the *right to offer relevant and competent evidence on a material issue*. Subject to such obvious qualifications as the court's power to restrict cumulative and rebuttal evidence . . . , and to exclude unduly prejudicial matter [citation], denial of this fundamental right is almost always considered reversible error. [Citations.]' [Citation.] Ordinarily, parties have the right to testify in their own behalf [citation], and a party's opportunity to call witnesses to testify and to proffer admissible evidence is central to having his or her day in court. [Citations.]" (*Elkins v. Superior Court* (2007) 41 Cal.4th 1337, 1357, original italics (*Elkins*).) A trial court's efforts to proceed expeditiously in the face of press of ongoing business " 'should never be directed in such manner as to prevent a full and fair opportunity to the parties to present *all competent, relevant, and material evidence* bearing upon any issue properly presented for determination.' " (*Ibid.*, original italics.)

These principles have been applied in civil cases in varied contexts. In *Elkins*, *supra*, 41 Cal.4th at page 1357, our high court concluded that a local court rule requiring that parties submit testimony in marital dissolution proceedings by declaration abridged the litigants' rights to testify on their own behalf and to present admissible evidence in support of their positions. In *In re Marriage of Carlsson* (2008) 163 Cal.App.4th 281, the appellate court held that the trial court, in abruptly terminating a trial before its conclusion, which had the effect of preventing the husband from presenting rebuttal expert testimony and completing his case in chief (*id.* at pp. 288-290), violated the husband's constitutional right to due process and a fair trial, thereby requiring reversal. (*Id.* at pp. 290-292.) In *Southern Pacific Transportation Co. v. Santa Fe Pacific Pipelines, Inc.* (1999) 74 Cal.App.4th 1232, the court held that the trial court's exclusion of the valuation reports of the plaintiff's expert, thereby preventing it from presenting

relevant evidence, deprived the plaintiff of a fair trial. (*Id.* at pp. 1246-1248; see also *Kelly v. New West Federal Savings* (1996) 49 Cal.App.4th 659, 677 [order granting in limine motion precluding plaintiffs' expert from testifying effectively prevented plaintiffs from presenting their case was reversible error per se].) And in *In re Amy M.* (1991 232 Cal.App.3d 849, a panel of this court held that the juvenile court's denial of the parents' request to call their eight-year-old son to testify, based upon a neutral evaluator's opinion that "it would be stressful" for the child (*id.* at p. 864), violated the parents due process rights, and that the error was not harmless beyond a reasonable doubt. (*Id.* at pp. 864-868; see also *Ingrid E. v. Superior Court* (1999) 75 Cal.App.4th 751, 759 [juvenile court abused its discretion by denying mother's due process right to a contested review hearing].)

While none of the above cases may be considered a close analogue of the matter presented here, we nonetheless cautiously consider whether the exclusion of the proffered surrebuttal testimony of Dr. Barnes deprived parents of a fair hearing in the sense that they were " 'prevent[ed] a full and fair opportunity . . . *to present all competent, relevant, and material evidence* bearing upon any issue properly presented for determination.' " (*Elkins, supra*, 41 Cal.4th at p. 1357, original italics.)

The basis for the juvenile court's ruling was that there was no need for Dr. Barnes's testimony because "Dr. Saket did not give any new opinions in his testimony." The court also observed that, in considering the matters about which Dr. Barnes would testify, it "[didn't] see that there's anything new. It's just a reiteration or yet another opinion by somebody. . . . [¶] . . . [A]ll of these issues have been addressed by two of [mother's] experts." Thus, a critical aspect of our review of the denial of surrebuttal testimony of Dr. Barnes is an understanding of the function and substance of Dr. Saket's testimony.

Preliminarily, we note that it was well within the juvenile court's discretion to permit Dr. Saket, the minor's treating radiologist, to testify in rebuttal to the testimony of

Dr. Gootnick. (*Charleville, supra,* 136 Cal.App. at p. 360.) The court qualified Dr. Saket as an expert for the limited purpose of "giv[ing] an opinion in pediatric neuroradiology as it relates to rebutting . . . Dr. Gootnick's opinion, as to the foundation of her opinion." And we acknowledge that the juvenile court was empowered to pose questions to Dr. Saket, as it did to a significant extent here. " ' "Within reasonable limits, it is not only the right but the duty of a trial judge to clearly bring out the facts so that the important functions of his [or her] office may be fairly and justly performed." [Citation.]' " (*People v. Carlucci* (1979) 23 Cal.3d 249, 256; see also *In re Emily D.* (2015) 234 Cal.App.4th 438, 446 [recognizing power of juvenile court to call and question witnesses in jurisdiction hearing].) But in this instance, we examine below whether such questioning may have resulted in the Department's expert, Dr. Saket, offering testimony and opinions beyond the scope of his role as a rebuttal witness.

First, we conclude that Dr. Saket's actual testimony was broader than the juvenile court's limited qualification that Dr. Saket could give opinions in his specialty that rebutted Dr. Gootnick's opinions and the foundation for them. Clearly, Dr. Saket offered some testimony that was proper rebuttal to Dr. Gootnick's opinions. Such proper rebuttal included Dr. Saket opining that Dr. Gootnick was incorrect in her conclusions that (1) the MRI scans showed only an empyema and not a subdural hematoma with acute blood; (2) the left-side subdural hematoma was related to the minor's difficult birth; and (3) there was no evidence on the MRI scans of a brain shearing injury.

But there was other testimony from Dr. Saket—including testimony elicited from the court's questioning—that was beyond the scope of rebuttal testimony. This beyond-the-scope testimony from Dr. Saket[19] included his opinions concerning the minor's meningitis. Specifically, based upon his later knowledge that the minor had meningitis

[19] Mother's counsel objected repeatedly that Dr. Saket was providing testimony beyond the scope of his role as a rebuttal expert.

on April 11, Dr. Saket opined that the fluid in the left-side subdural hematoma was pus or acute blood, a revision to his prior conclusion that there was a strong likelihood it was acute blood. Dr. Saket also testified that meningitis would not have caused the minor's chronic subdural hematomas, blood in the subarachnoid space, or the shearing injury to the brain. That these opinions by Dr. Saket were beyond the scope of rebuttal testimony is acknowledged by the Department in its respondent's brief: "[W]hile the juvenile court initially indicated it would allow Dr. Saket's testimony for the limited purpose of rebutting the foundational facts underlying Dr. Gootnick's opinion, it became clear to the court during [Dr. Saket's] testimony that additional information from [him] concerning the meningitis diagnosis was essential to the court's ultimate determination. . . . [T]he juvenile court recognized that it was important to know how the subsequent meningitis diagnosis impacted Dr. Saket's opinion."

In addition, there was other testimony presented by Dr. Saket beyond the scope of rebuttal. This testimony included his opinions that (1) there was to a 100 percent certainty a left-side chronic subdural hematoma; (2) there was a second chronic subdural hematoma on the right side; (3) there were bilateral subdural fluid collections that would not normally be present in a healthy baby; (4) the left-side fluid was acute blood, pus, or a combination of the two; and (5) there was acute blood in the subarachnoid space.

There was thus testimony from Dr. Saket that could not properly be considered rebuttal evidence. It included testimony from Dr. Saket concerning (1) the detailed explanation (i.e., from his testimony reviewing in detail the MRI scans as trial exhibits) of his neurological findings made on April 11, (2) additional opinions concerning the minor's condition not specifically mentioned in his written findings, and (3) his later awareness that the minor had meningitis on April 11 and how that additional information influenced his prior findings. With respect to the first additional area, it must be emphasized that Dr. Saket's neurological findings from the MRI scans were adopted by Dr. Albin. She testified that she had extensive discussions with Dr. Saket at the time

concerning the imaging after he had told her the MRI results were consistent with nonaccidental head trauma, and he had assured her that the brain shear injuries he had observed on the MRI were not related to seizures. Dr. Albin testified that she incorporated Dr. Saket's neurological findings in her report, and she was confident in the accuracy of those findings. Further, Dr. Albin admitted that her ability to identify some of the neurological conditions to which she opined was somewhat limited. Specifically, she testified it was beyond her expertise to identify on the MRI scans the specific characteristics of the brain shear injuries identified by Dr. Saket, and Dr. Saket was more qualified than she to identify the subarachnoid hemorrhaging. Therefore, to the extent Dr. Saket identified and described the neurological findings he made as a result of the April 11 MRI scans, he was reiterating (and thus emphasizing) the prior testimony of Dr. Albin and was offering evidence that the Department could have presented in its case in chief. Generally, this type of evidence is not proper rebuttal evidence. (See *Carter*, *supra*, 48 Cal.2d at pp. 753-754; *Lipman*, *supra*, 106 Cal.App.2d at p. 620.)

Second, we conclude—based upon our careful review of the record—that Dr. Saket, in fact, presented new evidence and opinions in his rebuttal testimony. He testified that he had not known the minor had meningitis on April 11 when he made his neurological findings, and this information caused him to modify his findings: Instead of there being a strong likelihood that the fluid in the left-side subdural hematoma was acute blood, he concluded the fluid could have been pus or acute blood. Dr. Saket also testified that meningitis would not have caused the minor's chronic subdural hematomas, blood in the subarachnoid space, or shearing injury to the brain—opinions that were obviously not part of his original report since he had not been aware of the minor's infection at the time he prepared it. He also opined that the left-side chronic subdural hematoma was not related to the minor's birth. Further, Dr. Saket testified that the MRI scans showed a black dot on the left side of the minor's brain that represented bleeding at the white junction of the cerebellum" evidencing a brain shear injury. Although a brain shear

injury is mentioned by Dr. Saket in his report, the specifics supporting his opinion were not presented in the report and it does not appear those specifics were known by parents until Dr. Saket's rebuttal testimony. It was therefore new evidence.

The Department argues—as it did below—that parents were aware of Dr. Saket's opinions before the hearing because his opinions were contained in the written report of his radiological findings attached to the Jurisdiction/Disposition Report. This argument ignores that much of the substance of Dr. Saket's testimony—including his opinions that the minor's meningitis was not the cause of his chronic subdural hematoma, subarachnoid hemorrhages, or shearing injury, his opinion as to whether the chronic subdural hematoma was caused by the minor's birth, and his extensive testimony explaining and interpreting the matters presented on the MRI scans—was not contained in the report.[20]

The offer of proof by mother's counsel was that Dr. Barnes would respond to Dr. Saket's opinions that (1) there were "different aged bleeds within th[e] chronic subdural hematoma," (2) meningitis was not the cause of the subarachnoid bleeding or the membranes Dr. Saket identified, and (3) a dot or dots on the MRI scans represented a brain shear injury. Giving consideration to the wealth of complex expert testimony presented, and in light of the ultimate breadth of Dr. Saket's testimony that included new evidence and opinions, it was entirely appropriate for mother to proffer surrebuttal expert testimony from Dr. Barnes. In light of the importance of the medical testimony to the

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[20] The Department also argues that the juvenile court properly exercised its discretion under Evidence Code section 352 to exclude the proposed surrebuttal testimony of Dr. Barnes because of its cumulative nature. There is nothing in the record indicating that the court denied mother's request for leave to present surrebuttal testimony under Evidence Code section 352. In any event, because we conclude that Dr. Saket presented new evidence and opinions for which surrebuttal was appropriate, we do not believe that the proposed surrebuttal testimony of Dr. Barnes was subject to exclusion as being cumulative.

outcome of the case, mother's presentation of this proposed surrebuttal testimony was an essential component of " 'a fair trial is the *right to offer relevant and competent evidence on a material issue*.' " (*Elkins, supra*, 41 Cal.4th at p. 1357, original italics.) Based upon the facts and the unique circumstances presented here, we conclude that it was therefore error to exclude the proposed surrebuttal expert testimony of Dr. Barnes.

5. Evidentiary Ruling Was Prejudicial

Mother contends that the juvenile court's error in denying leave to present Dr. Barnes as a surrebuttal expert, combined with the court's admission of, and refusal to strike, the testimony of Dr. Saket, violated her federal and state due process rights. Mother argues that the error deprived her of a fair hearing and was therefore structural error requiring automatic reversal. She asserts that if the error was not reversible per se, because the denial of a federal constitutional right is involved, the *Chapman* (*Chapman v. California* (1967) 386 U.S. 18, 24) standard of harmless error—i.e., that the error requires reversal unless it is established that the error beyond a reasonable doubt did not contribute to the adverse result—is applicable. Because, mother argues, the Department cannot establish the error was harmless beyond a reasonable doubt, reversal is required. Alternatively, mother contends that even if the less stringent *Watson* (*People v. Watson* (1956) 46 Cal.2d 818, 836) harmless error standard applies—whether it is reasonably probable that a result more favorable to appellant would have been achieved absent the error—reversal is nonetheless mandated.[21]

The concept of structural error derives from criminal cases. It is "only in rare cases [that the United States Supreme] Court has held that [a constitutional error] is structural, and thus requires automatic reversal." (*Washington v. Recuenco* (2006) 548

[21] The Department does not address in its respondent's brief the issue of the standard of harmless error applicable here or whether the error, under the appropriate standard, was prejudicial.

U.S. 212, 218, fn. omitted.) Examples of instances in which structural error was found include constitutional violations where a criminal defendant was deprived of the right to counsel (*Gideon v. Wainwright* (1963) 372 U.S. 335), was convicted after the jury was given a defective reasonable doubt instruction (*Sullivan v. Louisiana* (1993) 508 U.S. 275), or was convicted in a trial involving a biased judge (*Tumey v. Ohio* (1927) 273 U.S. 510).

The California Supreme Court, while not definitively stating that the concept of structural error in criminal appeals is inapplicable to dependency cases, has questioned the matter. In *In re James F.* (2008) 42 Cal.4th 901, our high court stated that the "significant differences between criminal proceedings and dependency proceedings provide reason to question whether the structural error doctrine that has been established for certain errors in criminal proceedings should be imported wholesale, or unthinkingly, into the quite different context of dependency cases. [Citations.]" (*Id.* at pp. 915-916.)[22] Nonetheless, appellate courts, in certain instances, have held that certain fundamental errors, such as the complete denial of a hearing (*In re Catherine H.* (2002) 102 Cal.App.4th 1284, 1293), or the failure to give notice of hearing resulting in the party's failure to appear, (*Judith P. v. Superior Court* (2002) 102 Cal.App.4th 535, 558), were reversible per se.

We conclude there was no structural error here. While parents were deprived of the right to present surrebuttal expert testimony to counter the evidence presented by the

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[22] The differences between criminal and dependency proceedings identified by the high court in *In re James* included the absence of a right to jury in dependency cases, the higher standard of proof beyond a reasonable doubt in criminal proceedings, the contrast in the subject matter of the trials (criminal trials being focused on determination of historical facts, while dependency proceedings being concerned with evaluations of a parent's ability and willingness to care for a child and the existence of suitable alternative placements), and the focus of dependency proceedings being the welfare of the child. (*In re James F., supra,* 42 Cal.4th at p. 915.)

Department on rebuttal through the testimony of Dr. Saket, they were in no way completely deprived of their right to a fair hearing. (Cf. *In re Catherine H., supra*, 102 Cal.App.4th at p. 1293.) To the contrary, parents, represented by separate counsel, participated fully in the protracted jurisdiction hearing, and the juvenile court afforded them ample opportunity to participate in the hearing, including permitting them to cross-examine the Department's two experts extensively and permitting mother to present two expert witnesses. There was no error requiring automatic reversal.

The harmless error standard of prejudice typically applied in dependency proceedings is the *Watson* standard of whether it is reasonably probable that a result more favorable to appellant would have been achieved absent the error. (See, e.g., *In re Justin L.* (1987) 188 Cal.App.3d 1068, 1077-1078.) But if the error is of a federal constitutional dimension, such as asserted here, where parents claim that the exclusion of Dr. Barnes's proposed testimony violated their federal due process rights, the applicable harmless error standard is less than settled. (See generally Seiser & Kumli, Cal. Juvenile Court Practice and Procedure (2018), § 2.194[2], pp. 2-744-748.) One court has held it appropriate to apply a standard that the error was harmless by clear and convincing evidence. (*In re Denny H.* (2005) 131 Cal.App.4th 1501, 1514-1515.) The court reasoned that, although the *Chapman* harmless beyond a reasonable doubt standard had been applied in some dependency cases, this application failed to recognize that the burden of persuasion standard of proof in dependency proceedings is often the clear and convincing standard. (*In re Denny H., supra*, at pp.4th 1514-1515; *In re Meranda P.* (1997) 56 Cal.App.4th 1143, 1157-1158, fn. 9 [questioning application of *Chapman* harmless error standard where "the criminal reasonable doubt standard of persuasion does not apply at any stage of a dependency proceeding"].) Other courts have applied the *Chapman* standard for constitutional errors in dependency proceedings. (See, e.g., *In re Mark A.* (2007) 156 Cal.App.4th 1124, 1144-1146 [rejecting *In re Denny H.* application of clear and convincing standard].)

We need not decide whether *In re Denny H., supra*, 131 Cal.App.4th 1501 or *In re Mark A., supra*, 156 Cal.App.4th 1124 offers the more persuasive view of the harmless error standard applicable to errors of constitutional dimension in dependency proceedings. Here, the exclusion of the proposed rebuttal testimony of Dr. Barnes was not harmless under either standard. As we have noted, Dr. Saket offered new opinions and evidence, and his testimony was beyond the scope of rebutting the foundation of Dr. Gootnick's opinions. Dr. Saket's testimony that he had not known the minor had meningitis when he prepared his report on April 11 and that this information caused him to modify his findings was new evidence. His testimony that meningitis would not have caused the minor's chronic subdural hematomas, blood in the subarachnoid space, or shearing injury to the brain were new opinions. Dr. Saket's view that the left-side chronic subdural hematoma was not related to the minor's birth was also a new opinion. And his explanations of what was shown on the minor's MRI scans, including the black dot noted on the left side of the minor's brain evidencing a brain shear injury, was new evidence.

The significance of Dr. Saket's testimony—and thus underscoring indirectly the importance of mother's proposed surrebuttal expert testimony of Dr. Barnes to address Dr. Saket's opinions—was highlighted by the Department's counsel in her closing argument. She noted that Dr. Saket on April 11 had interpreted the MRI scans as showing a chronic subdural hematoma, scattered subarachnoid hemorrhaging, and a brain shear injury all consistent with nonaccidental trauma. The Department emphasized that Dr. Saket had opined that the minor's chronic subdural hematoma was not birth-related, as such hematomas sustained at birth resolve after one to two months. The Department's counsel also highlighted in her closing argument that it was Dr. Saket's opinion that conditions he found from the MRI scans—"[t]he chronic subdural hematoma due to the membrane[,] . . . the subarachnoid hemorrhages confirmed by blood in the . . . subarachnoid space . . . and . . . the shear injury in the cerebellum"—were not caused by

meningitis.[23] She also noted that although Dr. Saket had originally concluded there was an acute subdural hematoma imposed on the chronic subdural hematoma, after having learned that the minor had meningitis, he revised his opinion in court to state that the acute subdural hematoma could have been blood or pus, or a mixture of the two. Furthermore, the Department emphasized that Dr. Saket's experience as a pediatric neuroradiologist reading infants' MRI scans was "tenfold [that] of Dr. Gootnick," and urged the court to "rely on the clear demonstration by Dr. Saket to confirm that [the minor's] injuries exist[ed]" in sustaining the allegations of the amended petition.

The importance of Dr. Saket's testimony was demonstrated further in the record in the juvenile court's announcement of its decision sustaining the allegations of the amended petition. The court recited in its reasoning that Dr. Albin, working in consultation with a multidisciplinary team of physicians that included Dr. Saket, concluded that meningitis had not caused the minor's head injuries. The court also found Dr. Saket's education and experience to have been superior to the credentials of Dr. Gootnick and Dr. Gabaeff, and it concluded Dr. Saket's "command of the MRI while expressing his opinion[s] . . . was impressive and unmatched by any of the other medical experts called to testify in this case." Additionally, the court found Dr. Saket to have been "credible and reliable in his opinion[s] and formed a strong foundation for Dr. Albin's opinions." And based upon the testimony of Dr. Albin, the court concluded that the Department had presented a prima facie case that the minor came within the meaning of section 300, subdivisions (a) and (b), thereby shifting the burden of producing evidence that parents were required to raise an issue as to the actual cause of

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[23] Elsewhere in her argument, the Department's counsel again stated that Dr. Saket had opined that meningitis was not the cause of the minor's chronic subdural hematoma, subarachnoid hemorrhaging or brain shear injury. She also emphasized again in her argument that Dr. Saket had opined that the minor's chronic subdural hematoma and his brain shear injury were not caused by meningitis.

the minor's injuries. (See § 355.1, subd. (a); see *In re A.S.* (2011) 202 Cal.App.4th 237, 243 [if agency meets its showing under § 355.1, subd. (a), the statutory presumption " 'shifts to the parents the obligation of raising an issue *as to the actual cause of the injury* or the fitness of the home' "].)

We conclude—employing either the *Chapman* beyond a reasonable doubt standard or the *In re Denny H.*, *supra*, 131 Cal.App.4th 1501 clear and convincing evidence standard—that the exclusion of Dr. Barnes's surrebuttal testimony was prejudicial. Based upon the circumstances of this case, including the importance of the medical evidence in general and Dr. Saket's testimony in particular, Dr. Barnes's testimony in response to Dr. Saket's opinions could have been of considerable benefit to the trier of fact. Moreover, particularly in light of the complexity of the medical issues in the case, affording mother the opportunity to present surrebuttal evidence could have facilitated mother's efforts to meet her burden, as shifted pursuant to section 355.1, subdivision (a), " 'of raising an issue *as to the actual cause of the [minor's] injury*.' " (*In re A.S.*, *supra*, 202 Cal.App.4th at p. 243.) The exclusion of the surrebuttal evidence was thus not harmless error.[24]

6. Conclusion

As the extensive discussion of the evidence presented above demonstrates, complex medical issues predominated in this lengthy hearing. Central to determining whether the minor was a child described under subdivisions (a), (b), and (e) of section 300 was the resolution of complex and conflicting expert testimony. From our careful review of the record, we conclude that Dr. Saket, as a rebuttal witness, offered both

[24] Because we conclude that mother should have been permitted to call Dr. Barnes as a surrebuttal expert witness and the error was prejudicial, we need not address parent's alternative argument that the court erred by denying mother's motion to strike the testimony of Dr. Saket. (*Benach v. County of Los Angeles* (2007) 149 Cal.App.4th 836, 845, fn. 5 [appellate courts will not address issues whose resolution is unnecessary to disposition of the appeal].

proper rebuttal evidence as well as new opinions and evidence for which surrebuttal expert testimony from Dr. Barnes was appropriate. As part of parents' right to a full and fair opportunity to present all competent, relevant and material evidence in support of their position, they should have been permitted to present Dr. Barnes's surrebuttal testimony. Because we cannot conclude that this error was harmless, we must reverse. Again, we express no opinion concerning the merits of the issues to be resolved by the juvenile court in the jurisdiction hearing.

III. DISPOSITION

The disposition order of August 23, 2017, and the underlying jurisdiction order of August 3, 2017, are reversed.

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BAMATTRE-MANOUKIAN, J.

WE CONCUR:

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ELIA, ACTING P.J.

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MIHARA, J.

In re A.Y.; DFCS v. S.Y.
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